tatum highlands medical associates

New Patient Intake and Medical History

PATIENT INFORMATION

Patient Name: _____ **Gender:** _____**Male** _____**Female** **DOB:** _____

Marital Status: _____**Married** _____**Divorced** _____**Widowed** _____**Single**

Race: _____**White** _____**American Indian** _____**Asian** _____**Black/African American** _____**Pacific Islander** _____**Other** _____**Decline**

Ethnicity: _____**Not Hispanic/Latino** _____**Hispanic/Latino** _____**Decline**

SSN: _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Emergency Contact: _____ **Relationship:** _____**Phone:** _____

FINANCIALLY RESPONSIBLE PARTY (If different than above)

Name:	**Relationship to Patient:**
SSN:	**DOB:**
Primary Phone:	**Work Phone:**
Address:	

PRIMARY INSURANCE

Name of Insured:	**Relationship to Patient:**
Insurance Company:	**Group #:**
Insurance Address:	**Policy ID:**
Insurance Phone:	**DOB:**
Employer:	

SECONDARY INSURANCE

Name of Insured:	**Relationship to Patient:**
Insurance Company:	**Group #:**
Insurance Address:	**Policy ID:**
Insurance Phone:	**DOB:**
Employer:	

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY

Previous Primary Care Physician: _____ **Phone:** _____

Please provide names and specialty of any medical specialists you see for your healthcare needs:

_____ _____

_____ _____

Do you have ANY ALLERGIES to medications? _____ **If yes, please list medications and your reaction to the medication:** _____

_____ **Patient Initials:** _____

Pharmacy (name/cross streets): _____ **Phone:** _____

Our office uses an E-Prescribe program, which allows us to electronically send prescriptions to pharmacies and to share prescription information with other providers involved in your healthcare. This program reduces medication errors, enhances patient safety, and gives us information on which medications are covered under your drug benefit coverage.

I give Tatum Highlands Medical Associates permission to enroll me in their E-Prescribe program at the pharmacy indicated above. _____**Yes** _____ **No** **Patient Signature:** _____

Please list ALL medications and supplements you are currently taking:

_____ _____

_____ _____

_____ _____

Have you ever had, or do you currently have any of the following medical conditions? (Please check)		
____ Abnormal Pap Smear	____ Emphysema/COPD	____ Irritable Bowel Syndrome
____ Anemia	____ Fibromyalgia	____ Kidney Disease
____ Arthritis/Joint Pain	____ Hearing/Vision Problems	____ Migraines/Headaches
____ Asthma/Allergies	____ Heart/Vascular Disease	____ Osteoporosis/Osteopenia
____ Bulging Disc	____ High Cholesterol	____ Prostate Disorder
____ Cancer	____ High Blood Pressure	____ Seizure Disorder
____ Congestive Heart Failure	____ Hyperthyroid	____ Stroke/CVA/TIA
____ Depression/Anxiety	____ Hypothyroid	____ Urinary Tract Disorder
____ Diabetes/High Blood Sugar	____ Immune Disorder	____ Uterine or GYN Problems
____ Eczema	____ Irregular Heartbeat	____ Vascular Disease

If cancer was listed, please indicate type: _____

Please list any other medical concerns or problems not listed above: _____

Patient Name: _____ **DOB:** _____

Do you have a family history of the following conditions? (Please check)	
____ Cancer, if so type: _____	Relationship:
____ Diabetes	Relationship:
____ Heart Disease	Relationship:
____ Kidney Disease	Relationship:
____ Obesity	Relationship:
____ Psychiatric Disorder	Relationship:

Please indicate any other family or medical history, which is not listed above and you feel is pertinent:

_____

_____

SURGICAL HISTORY

PROCEDURE	DATE	PROCEDURE	DATE

SOCIAL HISTORY

Do you currently use tobacco?	**_____ YES _____ NO**
If yes, how much do you currently smoke/chew on a daily basis?	
Did you use tobacco in the past?	**_____ YES _____ NO**
If yes, when did you quit?	
If yes, how much did you smoke/chew on a daily basis?	
Do you drink alcohol?	**_____ YES _____ NO**
If yes, how much do you drink per day/per week?	
Do you use ILLICIT or RECREATIONAL drugs?	
If yes, which drugs?	
If yes, how much per week?	
Have you ever been treated for drug or alcohol addiction?	**_____ YES _____ NO**
How would you describe your diet? (Health & Balanced, Average, or Poor)	
Do you currently exercise?	**_____ YES _____ NO**
If yes, how many days per week do you exercise?	
If yes, what activities do you do to exercise?	
If no, is there a physical reason why you do not?	

I consent to medical treatment and agree to pay all charges, deductibles, and/or copayments at the time of service. Tatum Highlands Medical Associates may release any necessary medical information to my insurance company to process claims. I authorize my health insurance company to make payments directly to Tatum Highlands Medical Associates for applicable medical benefits and costs associated with my care. I give Tatum Highlands Medical Associates authorization to receive and provide medical information from hospitals, urgent care facilities, and medical specialists who are involved in my medical care.

_____ _____ _____

PRINT Patient's Name **SIGNATURE of Patient or Guardian** **Date**

RELEASE OF MEDICAL INFORMATION AND PATIENT COMMUNICATON

Patient Name: _____ Date of Birth: _____

I authorize Tatum Highlands Medical Associates to relay any and all communications regarding my lab results, medical testing, referral information, billing/account information, and other pertinent health information in the following manner.

VERBAL COMMUNICATION:

Home Phone: _____ May we leave a detailed message? _____Yes _____ No

Cell Phone: _____ May we leave a detailed message? _____Yes _____ No

In addition, I give Tatum Highlands Medical Associates permission to disclose medical and billing/account information to the following individuals on my behalf. If left blank, we will speak with patient only.

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

PATIENT PORTAL

Our office uses a patient portal as a means of communication with our patients. Our portal is a secure communication link between you and our practice. You may utilize the portal to send messages to our staff, view health records, and lab and diagnostic tests. In addition, you can view medication history and request refills on existing prescriptions.

However, please be advised that the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions*. Information left on the portal will be addressed within 48 hours. If a request is left after normal business, the request will be addressed the next business day.* ***Patient Initials _____***

PRIVACY PRACTICES AND OFFICE AND FINANCIAL POLICIES:

I have had the opportunity to review and/or receive a copy of Tatum Highlands Medical Associates Privacy Practices, which are part of the yearly update packet. **_____Yes _____ No**

If I wish to change my release and communication information at any time in the future, I must complete and sign a new Release of Medical Information and Patient Communication form.

_____ _____ _____

PRINT Patient's Name **SIGNATURE of Patient or Guardian** **Date**

Tatum Highlands Medical Associates
OFFICE AND FINANACIAL POLICIES

Thank you for choosing Tatum Highlands Medical Associates and trusting us with your healthcare needs. Please review the following office and financial policies and complete the bottom of this document.

1. **FINANCIAL POLICY:** Please bring your insurance card to each office visit and have it when scheduling appointments over the phone. If your insurance changes, please verify that we are contracted with your new plan. If your insurance plan requires a copayment for office visits or you have an unmet deductible, **payment is due at the time of service**, and no exceptions will be made. Your insurance company may not cover all your healthcare costs, and your policy is a contract between you and your insurance company. It is your responsibility to know your policy and benefits, and know that **you are required to pay out of pocket for non-covered or denied services**. In addition, if you have an unpaid account balance for more than 90 days and your account is turned over to our outside collection agency, a collection transfer fee of $45.00 will be added to your account.

2. **CANCELLATION POLICY:** Patients are seen by appointment only and that time is reserved for you. When you don't show for an appointment or cancel with less than 24 hour notice, it is a financial loss for our practice and more importantly is an appointment we could have used for another patient. **Therefore, if we do not receive 24 hour notice for a cancellation or you no show for an appointment, you will be charged a $25.00 fee.**

3. **MEDICATION REFILLS:** We do not prescribe medications over the phone. You must be a patient of record and be seen by one of our providers in order to receive a prescription. It is your responsibility to keep track of your medication supply. For refills of existing prescriptions, you should call your pharmacy directly or call our office during normal business hours. **Messages left for our Medical Assistants will be handled within 48 hours**. If a request is left after normal business hours, it will be addressed the next business day.

   Please note, many medications and all controlled substances require an appointment with your provider at least every 90 days, so scheduling routine visits will be necessary if you are prescribed any of these medications.

4. **PATIENT PORTAL:** Our online patient portal is available for you to access patient information, ask clinical questions, and request prescription refills. However, **the patient portal is for routine matters and NOT for URGENT or EMERGENT requests or questions**. Information left on the portal will be addressed within 48 hours. If a request is left after normal business hours, the request will be addressed on the next business day.

5. **AFTER HOURS:** The provider on call is available for urgent and emergent problems only, and is not available for routine matters such as discussing labs, x-rays, or refilling prescriptions. If you require urgent medical attention you should call 911 or go to your nearest Emergency Department or Urgent Care.

6. **TREATMENT OF MINORS:** Patients under 18 must be accompanied by their parent or legal guardian.

7. **MEDICAL RECORDS:** If you request copies of your medical records, we provide the first 5 pages free of charge. However, if your records exceed 5 pages you will be charged a $25.00 fee.

8. **FORMS:** Your provider is willing to complete medical forms you may need for FMLA, Worker's Compensation, Short or Long Term Disability, and other medically necessary forms, however there will be a $25.00 fee to complete these forms and payment will be collected when forms are dropped off. Completed forms will be available 48 hours after the forms and the payment is received in our office.

I acknowledge that I have read and understand Tatum Highlands Medical Associates' Office and Financial Policies and agree with the policies as outlined above.

_____	_____	_____
PRINT Patient's Name	**SIGNATURE of Patient or Guardian**	**Date**

Civility Policy

To our valued patients,

At Tatum Highlands Medical Associates, we train our staff to be respectful and courteous to each other and to our patients. Our employees play an important role in your care and as an extension of our providers they too need to be treated with respect.

Our *Civility Policy* is intended to promote a culture based upon mutual respect and professional communication. As your healthcare team we understand the importance of our relationship with our patients. Our goal is to provide exceptional patient care for the overall health and well-being of our patients and to provide a safe and respectful work environment for our staff and patients.

Our *Civility Policy* has no tolerance for disrespect. Therefore, we expect all parties to speak and act in a respectful manner. This policy does not permit the use of disrespectful or condescending language to staff, providers, or patients. Minor issues will be addressed in the spirit of conflict resolution, but egregious violations may result in patients or staff being dismissed from our practice.

We recognize you have a choice in your healthcare provider and we appreciate that you have chosen our practice. However, to continue our healthcare relationship we need our patients and staff to agree to our policy. If for some reason our *Civility Policy* is not agreeable for you, we will be happy to forward your records to a practice that is more suitable to your needs.

We look forward to working together and addressing the healthcare needs for you and your family.

Respectfully,

Peter F. Levins, M.D.

Peter F. Levins, M.D.
Medical Director
Tatum Highlands Medical Associates

I acknowledge that I have read, understand, and agree to abide by Tatum Highlands Medical Associates' Civility Policy. Failure to abide by the policy as outlined above may result in dismissal from this practice.

_____	_____	_____
PRINT Patient's Name	**SIGNATURE of Patient or Guardian**	**Date**

tatum highlands medical associates

Dr. Peter Levins, MD Nicole Fields, FNP Cari Montoya, FNP Ashley Hatch, FNP

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____

The above named patient is authorizing the release of their medical records and personal health information.

I authorize the release of my medical records, please SEND my records TO:

_____ **Tatum Highlands Medical Associates**

26224 N Tatum Blvd., Suite 15A
Phoenix, Arizona 85050
Phone 480-663-9632
Fax 480-419-6782

_____ **Other Facility (address below)**

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Reason for request: _____

I authorize the release of my medical records, my records will be sent FROM:

_____ **Tatum Highlands Medical Associates**

26224 N Tatum Blvd., Suite 15A
Phoenix, Arizona 85050
Phone 480-663-9632
Fax 480-419-6782

_____ **Other Facility (address below)**

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I authorize you to send the following (check all that apply):

_____Complete Medical Records
_____Progress Notes
_____Lab/Pathology Reports
_✔_Immunization Records
_____Cardiology/EKG Reports
_____Imaging Reports

By signing below, I understand that authorizing the release of medical records and personal health information is voluntary and therefore I release Tatum Highlands Medical Associates, their providers, and their employees from any and all liabilities, damages, and claims which may arise from the release of information. In addition, I understand that disclosure of this information may not be protected by federal confidentiality rules.

I also understand that information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), and information about behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization may be revoked at any time, however the revocation must be submitted in writing to Tatum Highlands Medical Associates and does not apply to health information which has already been released.

Patient Signature: _____ **Date:**_____